H.B. 843 Kentucky Commission on Services and Supports for Individuals With Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis
July 12, 2006
Capitol Room 129
Frankfort, Kentucky

Commission Members Present: Representative Mary Lou Marzian, Secretary Mark Birdwhistell, Representative Charlie Siler, William Hacker, John Burt, Norman Arflack, John Rees, Robin Ritter, Rosemary Luckett, Bill Heffron, Bill Cooper, Connie Payne, Tom Emberton and Ken Schwendeman.

WELCOME

- Co-Chair Representative Marzian called the meeting to order and made brief introductory remarks.
- Representative Marzian welcomed everyone to the HB 843 Commission meeting and thanked them for their participation.
- Secretary Birdwhistell asked for a motion to approve the minutes from the May 2006 meeting. Connie Payne made the motion and Representative Siler seconded; Commission members approved.
- Secretary Birdwhistell welcomed new members who were in attendance and stated the new appointments to the Commission would be forthcoming.

A Systems Response to Persons in Psychiatric Crisis – Panel Presentation

History and Introduction
Rita Ruggles

Rita Ruggles, specialist with the Division of Mental Health and Substance Abuse Services, presented an overview of the upcoming September 13th working retreat. Over the last three to four years, the state of Kentucky has lost over 300 inpatient psychiatric beds in private hospitals. The state hospitals have seen an increase in admissions due to the loss of the private sector beds, but have received no increase in funding to manage the needs. Local emergency rooms are being utilized as the first point of contact for behavioral health care which is a very expensive option. The problem is impacting multiple providers and the solution rests with improved collaboration across all systems of care including public and private providers.

Statewide, there has been an increase in admission rates at the state hospitals, an increase in readmission rates that is double the national average, and a decrease in length of stay, resulting in persons being discharged too soon.

Representative Marzian asked why Kentucky's readmission rates for the state psychiatric hospitals are double the national average.

Rita explained that due to the lack of funding for community based services, there has been an increase in admission and readmission rates. People with severe and persistent mental illness could be maintained in the community with added supports, but when there isn't enough funding to provide those supports, their symptoms increase and they end up admitted to the inpatient facilities. In addition, the overall increase in admissions and lack of available beds result in early discharge before the person is fully stabilized therefore resulting in readmission. These are the consequences that occur due to lack of funding for community based care and supports.

Rita said that a workgroup has been studying this issue for the last year and a half. The workgroup consists of representatives from the Kentucky Hospital Association (KHA), Department for Mental Health and Mental Retardation (KDMHMRS), Kentucky Association of Regional MH/MR Programs (KARP) which represents the Community Mental Health Centers (CMHCs), State Hospitals, KY Mental Health Coalition, and state and local

law enforcement officials. The workgroup identified that various types of relationships exist between private hospitals, regional mental health centers and the state psychiatric facilities. These relationships range from formal to informal and are different in each region. Strengthening the relationship between the multiple stakeholders responsible for serving this population became a focus of the workgroup.

The KDMHMRS submitted a technical assistance grant to the National Association of State Mental Health Directors (NASMHPD) to bring a consultant to Kentucky to facilitate a project that focuses on and identifies problems within the system surrounding these issues and suggests solutions to address them. The Department was awarded the grant and the facilitator from NASHMPD will be in Frankfort on September 13th and on December 13th to conduct two full-day retreats with Commission members and invited guests.

The following panel members were introduced to speak on how these issues impact and affect their systems.

Kentucky Hospital Association
Nancy Galvagni

Nancy Galvagni stated that KHA conducted surveys in 2002 and 2006 regarding this issue. The survey was sent to 70 hospitals, mostly rural facilities. There are 69 hospitals in the state that have fewer than 100 beds and are in a rural location. There was a 54% response rate of the hospitals surveyed. Most hospitals use their local CMHC's to conduct assessments when an individual presents in the emergency room. Even in areas where crisis stabilization services are available, federal law requires that hospital emergency departments assess, stabilize and transfer or treat a patient before the patient leaves the hospital. In the event the hospital does not have appropriately-trained staff available to perform this assessment, holding a patient for an extended period of time waiting for a mental health professional to conduct an assessment strains the limited resources of the emergency department. When the hospital requests that CMHC staff conduct an assessment, the expectation is that the CMHC will respond within two hours. Some of the barriers to a timely response include a lack of available CMHC staff, absence of a contract with the local CMHC, legal issues, the patient's medical condition and transportation.

When comparing the survey results from 2002 and 2006, there has been very little change. Hospitals that use CMHC's are frustrated by a slow response time, which is primarily caused by lack of staff, significant workload, and lack of working relationship between the hospital and the CMHC. A concern revealed by the survey is that there is no consistent system in place statewide that identifies who has the responsibility to transport patients to an appropriate level of care facility. The hospitals having the most success in addressing the transportation issue have created their own systems working with local law enforcement.

Secretary Birdwhistell asked if the hospitals that completed the survey were identifiable so that the CMHC and the hospital can come to the table and try to fix some of these issues. In addition, he asked if substance abuse was identified in any of these incidents, or is substance abuse unidentifiable when doing an assessment? He asked if there were issues about the payer source such as Medicaid versus private insurance?

Nancy responded that it would be possible to go back to the survey results and identify the hospitals that were having problems and the regions where they were located. The survey did not identify whether an individual had private insurance or Medicaid, but the results indicated that there were more problems and obstacles surrounding those patients who were uninsured.

Rita Ruggles said that substance abuse wasn't looked at specifically, but that many clients have co-occurring disorders. For the purposes of the survey mental health issues and substance abuse were not diagnostically separated.

Secretary Birdwhistell stated that if in the future we could sort out some of the programmatic components of these issues we could then solve some of them.

Representative Marzian asked if the hospital emergency departments had contracts with the regional CMHC's to conduct these assessments and if the CMHC's were reimbursed for those services?

Rita Ruggles stated that according to the existing statutes, the CMHC's are required to do an assessment at an emergency room only when the circumstances indicate a potential involuntary commitment under KRS Chapter 202A. But for someone who voluntarily comes to an emergency room, the CMHC's are not required to send one of their staff members to that emergency room. There is no funding stream or source of reimbursement for those services. The arrangements between the private entities and local CMHC's in each region – if they do exist – are not consistent.

Representative Marzian asked whether the rural hospitals have any inpatient psychiatric beds. Nancy answered that only four hospitals out of the 69 rural hospitals that were surveyed have inpatient psychiatric beds. The psychiatric beds are located primarily in the larger hospitals.

- ❖ See meeting handouts for additional information.

Marshall Emergency Services
Dr. Sandy Geile

Dr. Geile said that during a normal emergency room shift, there is approximately one client a day who comes for services that would be better served by a mental health professional than in the emergency room. Unfortunately, most of the small hospitals don't have mental health professionals available.

Dr. Hacker asked what the overall number of patients was per day who present in the emergency room. Dr. Geile said that approximately 70 patients come into the emergency room in the larger hospitals where she is on staff and approximately 40 patients per day at each of the two smaller hospitals.

Dr. Geile presented a case where a male client showed up voluntarily at the emergency room with a substance abuse/alcohol problem. He had previously tried to commit suicide and was seeking medical detoxification. The CMHC in the region has tightened some of their policies and are not evaluating or assessing patients when they are intoxicated. The crisis counselor could not come to the emergency room to assess the patient until he was sober. After about 4 hours, he was sober and the CMHC conducted the assessment over the phone. There were no residential facilities in the region that had space available to accommodate the client, so he remained in the hospital until a facility could be found. Because of his risk of suicide, the physician wanted him to be transported via ambulance. However, the emergency medical services legislation exempts psychiatric conditions from classification as a medical condition and therefore an ambulance would not transport him to the facility. Another county was able to provide transportation for this individual and he was taken to a mental health facility there. Unfortunately this is a common scenario across the Commonwealth.

The second case that Dr. Geile presented was an individual who came into the emergency room who was bi-polar and had no substance abuse problem. Her family brought her to the hospital and she was admitted using the 202A procedures. Once the patient was medically stable, which was after normal business hours, there wasn't anyone to do the mental health assessment. Under the 202A requirements, the EMS and/or law enforcement personnel are required to stay with the patient until the assessment can be completed.

Senator Borders asked how many people fall through the cracks of the system due to the lack of timely assessments. Rita Ruggles stated that currently 20% of the population is using 80% of the resources. These are cracks in the system that need to be corrected in order to better utilize the resources that are available to help more individuals.

Representative Marzian asked why in certain regions was there not a judge available after hours to issue a 202A order if requested. This seems like a problem that could be addressed by the Administrative Office of the Courts.

Connie Milligan stated as a point of clarification that Eastern State Hospital does have a psychologist or ARNP available for evaluations 24 hours a day. This does not take away the complaint from law enforcement or sheriff personnel about the time it takes to transport a patient to the hospital or to stay at the hospital waiting for the evaluation to be completed. This is a problem that has been identified across the state.

Community Mental Health Center
John Walker – Pennyroyal Region 2

John Walker stated that the Regional MH/MR Boards (the CMHCs) have an agreement with the KDMHMRS to provide "designated services to priority populations." Local hospital emergency rooms have an expectation that the CMHC's should be available to evaluate their patients for mental health issues prior to the individual being released from the hospital. However, performing these psychiatric assessments for hospital ER patients is not a core service for the CMHC's and KDMHMRS does not specifically provide funding for it.

The CMHC's have not had an increase in state general funds in more than twelve years. The Medicaid reimbursement rates have not been adjusted since FY 2000. Providing non-reimbursed services to the community has been almost impossible, due to the erosion of overall funding over the past decade.

Federal regulations (CORBA and EMTALA), state statutes (KRS 210.040 and 202A), service agreements with KDMHMRS, agency missions and stakeholder expectations all add to the complexity of this problem. Responding to local hospital emergency room requests for consultation services is important, but these services must be funded. Contracts could be developed between the CMHC's and local hospitals to better serve the voluntary patients at the hospitals. Where these contracts are in place, the response to these individuals is able to be made in a timelier manner.

- ❖ See meeting handouts for additional information.

Western State Hospital
Steve Wiggins

Steve Wiggins discussed the significant increase in admissions at Western State Hospital over the last few years due to the closing of private psychiatric beds in the region. The budget allocation for Western State Hospital has averaged a 2% increase per year over the last five years. Most of this increase was used to pay for employee salary increases due to legislated raises.

The number of court-ordered psychiatric evaluations has increased by 75% from 2001 to 2005. Western State Hospital is often the best and only alternative for the courts when dealing with difficult individuals who require inpatient psychiatric evaluation and treatment. In addition to the increase in admissions, the patients that are being admitted are more medically fragile than in the past. Often patients are sent to a local hospital for their physical health treatments. However, because those hospitals don't have psychiatric beds, Western State must send one of its staff with the patient for the hospital stay.

Steve also noted that pharmaceutical costs for the hospital have increased at an alarming rate of 15% to 20% each year since 2001. Sixty to seventy percent of the admissions also include substance abuse issues and Western State does not have the staff to provide medical detoxification to these individuals, a situation which can lead to a medical emergency.

Representative Marzian thanked Steve Wiggins and John Walker for their presentations and said they were very helpful in identifying some of the problems surrounding this issue.

Secretary Birdwhistell asked John Walker whether the CMHC's have been addressing this issue in their annual reports. John Walker responded by stating that Region 2 – Pennyroyal is reporting quarterly and has included these issues in their reports as an area that needs to be addressed and improved.

Secretary Birdwhistell said that there isn't anyone who doesn't want to fix the problem but that no one is stepping forward in defining any solutions. He commented that additional efforts need to be made to identify workable solutions.

Robert Hicks recommended that the CMHC's meet periodically with the other providers in their regions to discuss some of these issues and the obstacles. He suggested all work together to develop solutions and build collaboration among all the community stakeholders involved.

- ❖ See meeting handouts for additional information.

Consumer Perspective
Molly Clouse

Molly Clouse gave an overview of the system from a consumer perspective. Molly stated that people with mental illness can and do recover. There is hope for people who present at the local emergency rooms who are having a psychiatric crisis as long as they can obtain the help they need in a quick, efficient manner that does not exacerbate their crisis. People should be able to obtain the appropriate treatment, at the appropriate level, at the appropriate time, for the appropriate length of time that it takes to recover. It is complicated because each person's needs and treatment will be different. Since people are getting discharged sooner, additional community services are needed. There aren't enough services available in the communities, but peer support is needed and can be utilized in communities where no other services are available.

Strategic Planning & systems Mapping Overview
Rita Ruggles

Rita Ruggles thanked the panel members for taking the time to present on behalf of the stakeholders they represent. Rita discussed the systems mapping process that will take place at the retreat meeting on September 13th.

The systems mapping project is a strategic planning process that ensures multiple perspectives of the problems identified, and that the solutions developed have considered all of those perspectives. The process will include the point of view of the consumer of services and encourage more formalized collaboration among systems to prevent inappropriate use of expensive services unless absolutely necessary; decrease hospital admissions; engage people in treatment as soon as possible; and decrease the rate of return to the emergency room as a preferred provider of mental health services in the community.

The retreat will be an opportunity for the HB 843 Commission to work collaboratively to address the revolving door between the hospital and the community for persons with mental illness, substance abuse and co-occurring disorders. On December 13, 2006, the facilitator will follow-up the September 13th retreat with tools and actions to develop solutions to the issues identified at the September 13th retreat.

Murray Wood asked if the children's system of care was going to be addressed or if this retreat focused on the adult system of care.

Rita explained that this upcoming systems mapping project focused on the adult system of care, but the overall process and concept can also be utilized to identify and work out solutions in the children's system.

Representative Siler reiterated that the conflicts and inconsistencies in statutes and regulations need to be identified and changed through the legislative process. He is concerned that people who are mentally ill get the treatment they need and are not simply incarcerated. He wants to make sure that funding is increased to meet the needs for treatment services.

Next Meeting/Next Steps

Commissioner Burt presented a request to the HB 843 Commission on behalf of the KY Suicide Prevention Group (KSPG) steering committee to have the involvement of a legislator in group meetings and activities. Because KSPG is technically a workgroup of the HB843 Commission, seeking input from the HB 843 co-chairs seemed to be the appropriate next step. The KSPG requested that the HB 843 co-chairs authorize the KSPG chair, Mr. Denis Walsh, to recruit a legislator to participate. Representative Marzian and Secretary Birdwhistell agreed to this request.

The HB 843 Commission working retreat for commission members and invited guests is scheduled for September 13 with a follow-up retreat scheduled for December 13, 2006. Both retreats will be held at Berry Hill Mansion in Frankfort; more detailed information will follow.

With no further business, the meeting was adjourned.